Project to Improve Independent Medical Examinations
For the State of Washington
Department of Labor and Industries

Chapter 2

Problem Statement

Downloadable Version, Part 6 of 6

Originally submitted as Deliverable 2

MedFx, LLC
Mill Valley, CA
December 2001

Table of Contents

Appendices appear in a separate accompanying volume

Detailed Audit Results

In this section we present more complete explanations of areas in which observed practices almost universally fell short of criteria for excellent IMEs. Observations come from both the examination request materials and the quantitative audit of the IME reports. The organization of this section follows that used in the Deliverables 4, 5, and 6. The observations made here describe practices that may be improved when compared to those developed in Deliverable 6, the synthesis of the literature review and the national survey of claims organizations and state regulators.

These content area findings will be followed by the numerical audit findings, which are sequenced in the order of the process in which an IME is conducted, rather than by issue.

Claim Characteristics

- Demographics
    - The audit revealed that 3.4% of claims were closed at the time the IME was obtained, and 96.6% were open.
    - Claimants in 15.2% of the cases were represented by an attorney.
    - A minority of the claimants had multiple IMEs:
        - 63.3% had no previous IME;
        - 15.2% had one previous IME;
        - 8.0% had two previous IMEs;
        - 13.4% had three or more previous IMEs.

Who Does Examinations

- Almost all requests from Washington L&I go to IME broker companies.
- Almost all examinations are done at IME broker company locations.

- Most requests are for multi-examiner exams.
- A small number of individuals and pairs of examiners do most of the exams.

Request Letters and Materials

- Letters rarely asked focused questions tailored to the specific circumstances of the case.
    - As a rule, they did not define the specific issue in dispute.
    - Letters almost always asked the examiner to establish a diagnosis and verify causation, even in long-established claims and closing exams where these issues are moot.
    - MMI questions were very common. There was rarely evidence in the files reviewed of the AP stating if the patient was at MMI or if the patient had recovered to his or her pre-injury state.
        - If the answer to MMI was "no," a treatment plan was requested;
        - If the answer to MMI was "yes," a permanent impairment rating was requested.

- Questions about temporary or permanent restrictions in ability to work were unusual.
    - There was rarely any guidance about job modifications or job accommodation available.

- Letters never documented which specific medical record and file materials were sent to the examiner for review.

Examination and Report Process

- Positive identification of the claimant was not documented in any of the reports.
- The reports only occasionally stated that the examiner had identified himself or herself.

- The explanation of the exam process to the worker was rarely documented in IME reports.
- The amount time of spent directly with the examinee and overall with the evaluation was never recorded.
- No list of documents reviewed was presented in any report audited.
- Time spent reviewing records was never recorded.
- Dates of dictation and signature were not given.

IME Report Content

- Weaknesses that were often found in case summaries:
    - Records reviews were typically just brief summaries.
    - Records were sometimes cited without dates.
    - Discussions of records were often missing important details.
    - Key test results were often missing, with only the interpretation given.
    - Fairly often, records reviews were combined with the history obtained from the worker, with no distinction given.

- Key facts that were typically missing from reports or only briefly presented included:
    - Symptoms, signs, and tests immediately post injury
    - Findings at surgery
    - Prior relevant jobs
        - The required Carpal Tunnel Syndrome (CTS) reports or data, which include this detailed occupational history, were not observed.
    - Work history from date of injury
    - Current functional level
        - At work
        - Activities of daily living

- Assessments of the following were typically missing:
    - Prior record content and quality
    - Prior diagnostic process and diagnoses
    - Prior treatment
    - Behavioral findings, especially non-physiologic findings
    - Claimant consistency and reliability

- Recommendations for further tests or treatments were often inadequate:
    - Examiners often say no further treatment is needed:
        - They are generally correct.
        - There have often been (multiple) medically unnecessary procedures.
    - The rationale for treatment recommendations was rarely cited:
        - Adequate conservative therapy was not well summarized.
        - Compliance with previous treatment was generally not documented.
        - We observed no comparison to evidence-based guidelines.
    - Sometimes treatment options were limited to surgery:
        - Indications were often unclear.
        - The rationale for surgery was generally not cited.
    - The rationale was sometimes at odds with tests, physical findings, and the evidence base.

- Explanation of the logic and basis for opinions were rarely present except sometimes in ratings
    - Ratings uniformly failed to reference specific criteria, such as Tables and Figures in the AMA Guides to Permanent Impairment
    - No ratings provided attached impairment evaluation documents, such as Figure 1: Upper Extremity Impairment Evaluation Record from the AMA Guides to Permanent Impairment, Fourth Edition

- Shoulder ratings were generally well explained
    - Several were erroneous, inappropriately combining strength loss or neglecting to incorporate impairment for distal clavicle resection.
- Low back and CTS ratings were generally poorly explained

Assessing Causation

Causation analysis was one of the weakest areas in this sample of IME reports. Little of the specific historical information needed to correlate a work event or exposure with an injury was present in most reports. Most often, prior attribution to work was simply accepted, even when illogical. For example, disk protrusions were attributed to bending or twisting with little apparent force exerted.

It is important to note that the issue of causation is most likely moot in an MMI or closure evaluation. The case was accepted long ago. However, since the examiner is almost always asked to assess causation, the analysis should adhere to reasonable standards for causality assessment.

- Issue: Adequacy of factual basis for opinion
    - Review of accident report not documented
    - Minimal documentation of patient history of incident
    - Little documented questioning for previous injuries
    - Prior surgeries to affected body part were usually not documented except as imaging findings
    - Inadequate occupational and non-occupational exposure histories
        - Only found in psychiatric IMEs
    - Missing history of working conditions
        - Only found in psychiatric IMEs
    - Lack of focus on time-critical symptoms, findings
        - At time of injury and at first medical visit

- Issue: Accuracy of analysis and opinion
    - Explicit comparison of medical facts with incident facts is rare
        - Often simply a repeat of previous MD opinions
    - Questionable consistency with evidence
        - No comparison to literature
    - Apparent acceptance of condition or prior conclusions

Quantitative IME Report Audit Findings

In this section we present the numerical IME report audit findings, sequenced in the order of the process in which an IME is conducted.

Records Review

Records reviews tended to be somewhat cryptic, most often containing brief descriptions of data such as the claimant's job at the time of injury, the mechanism of injury, and the claimant's symptoms at the time of injury. Most prior relevant jobs were not listed, nor were signs at the time of injury and tests and results at the time of injury (Table 1).

Table 1

History of Injury from Records Review

History Item	Full Description	Brief Description	Reported as Not an Issue	Not recorded
Prior Relevant Jobs	2.1%	21.0%	0.3%	76.5%
Job at Time of Injury	16.0%	67.8%	0	16.1%
Mechanism of Injury	33.0%	42.8%	0	23.7%
Symptoms at Time of Injury	29.1%	46.3%	0	24.6%
Signs at Time of Injury	13.4%	16.4%	0	70.2%
Tests at Time of Injury	9.9%	29.4%	4.6%	56.1%

Past Health History

Once again, most past history was briefly noted, without enough detail to determine if the prior illnesses, injuries or surgery had residual effects that would bear on apportionment, causality, and effective therapy (Table 2). In about half of the cases, prior surgery on the affected part of the body and allergies were not noted.

Table 2

Past Medical and Surgical History

History Item	Full Description	Brief Description	Reported as Not an Issue	Not recorded
Past Medical History	17.9%	59.6%	4.8%	17.7%
Prior Injury to Currently Injured Part of Body	25.7%	24.7%	37.8%	11.8%
Prior Surgery on Currently Injured Part of Body	8.0%	18.5%	30.6%	42.0%
Other Prior Procedures	10.4%	51.2%	9.3%	29.1%
Allergies	7.1%	31.2%	13.3%	48.4%

Risks for Delayed Functional Recovery

Certain values of the following data have been shown to correlate with delayed return to work. Examples include low education level, tenuous or changing living arrangements, substance abuse, family role change and family conflict. This information was reported either briefly or not at all (Table 3). The only clear, complete descriptions of these data were presented in psychiatric IME reports, although their acquisition and interpretation should be a part of the skill set of an independent medical examiner.

Aside from being part of the best practice data set, the information would have been useful in most of the cases for which reports were audited, as they often had protracted absence from work beyond the expected recovery time for the injury sustained. The information could have been used to differentiate functional from physical disability, and to more appropriately formulate case management and rehabilitation plans.

Table 3

Risks for Delayed Functional Recovery

History Item	Full Description	Brief Description	Reported as Not an Issue	Not recorded
Family History	8.5%	55.1%	8.5%	27.9%
Marital Status	10.7%	68.9%	0	20.4%
Living Arrangements	5.7%	15.7%	0	78.6%
Education Level	20.5%	57.0%	0	22.5%
Substance Use	23.9%	48.9%	5.1%	22.0%
Other Health Risks	5.7%	21.8%	2.9%	69.9%

Functional Abilities

It is important for the examiner to explore and document the claimant's ability to function at home, in social and recreational activities, and in activities of daily living as well as at work. Once again these data were collected briefly, usually as comments related to other issues rather than as a separate, discrete topic. (These instances were classified as "brief" in Table 4.) Inconsistencies among functional levels in different settings can be a clue to difficulties in the work setting, and can also more fully document actual functional impairment. These findings tended to be more clearly presented in psychiatric reports.

Table 4

Functional Abilities

History Item	Full Description	Brief Description	Reported as Not an Issue	Not recorded
Work History	12.4%	65.7%	0	21.9%
Activities of Daily Living	10.3%	41.8%	2.1%	45.9%
Functional Status	15.6%	50.6%	0	33.8%

History of Present Illness or Injury

The history of tests and treatment to date as obtained from the patient should be compared to the history obtained from the records review. In most reports audited, the patient history was more complete than the record review. Anecdotally, record sets were often said to be incomplete or illegible. The imaged records provided to the auditors tended to substantiate this impression, making the claimant history even more important. Again, the data tended to be briefer than desired (Table 5).

Table 5

History of Present Illness or Injury

History Item	Full Description	Brief Description	Reported as Not an Issue	Not recorded
Tests to Date	26.2%	57.2%	1.8%	14.8%
Treatment to Date	31.1%	62.7%	0	6.2%

Current Status

The claimant's current health and functional status is obviously important to the evaluation of impairment as well as the ability to return to work productively. With the exception of current symptoms, these data tended to be recorded more briefly than desired, and omitted in about a third of the reports (Table 6).

Table 6

Current Status

History Item	Full Description	Brief Description	Reported as Not an Issue	Not recorded
Current Symptoms	47.9%	45.3%	1.6%	3.3%
Current Activity Level	8.6%	55.2%	0	36.2%
Current Medications	21.6%	39.9%	8.2%	30.3%
Review of Systems	9.3%	49.4%	10.1%	30.9%

Physical Examination Content

A clear representation of physical findings is the core of the independent medical examination as it is presently used in Washington, since impairment is recognized primarily for physical factors. Easily observable general, behavioral, and non-physiologic findings were recorded briefly or not at all. The majority of positive physical findings were adequately described, but a substantial number of reports tended to lack the detail needed to reproduce later diagnoses or analyses (Table 7).

Table 7

Physical Examination

Examination Item	Full Description	Brief Description	Reported as Not an Issue	Not recorded
Height, weight, vital signs	46.2% (Recorded)	53.9% (Not recorded)		
General Appearance	19.2%	35.3%	0	45.6%
Behavioral Findings	11.9%	14.0%	3.5%	70%
Non-physiologic Findings	17.2%	6.1%	11.7%	65.0%
Positive Findings	59.3%	35.5%	1.5%	3.7%
Negative Findings	34.4%	48.5%	n.a.	7.1%

Examinee Credibility and Consistency

An explicit assessment of the claimant's credibility and consistency as a historian is needed to evaluate the credence of the historical data reported, and to compare the history, particularly function, with the physical examination. These assessments were rarely in evidence (Table 8).

Table 8

Examinee Credibility and Consistency

Issue	Full (5)	4	Unclear (3)	2	Not (1)	Not Recorded
Examinee Credibility as a Historian	1.0%	2.3%	3.2%	5.5%	1.0%	87.0%
Examinee Consistency as a Historian	0.3%	1.8%	3.2%	3.9%	0.9%	89.9%

Conclusions from the Records Review, History and Physical Examination

The majority of diagnoses were clearly stated, but many were brief lists. The situation was similar for treatment recommendations, both positive and negative. The examiner's prognosis for further improvement and ability to return to work was missing in about a third of the cases in which these data were relevant (Table 9).

Table 9

Conclusions

Conclusion	Full Description	Brief Description	Reported as Not an Issue	Not recorded
Examiner's Diagnosis	58.6%	32.3%	7.0%	2.1%
Treatment Recommendations	35.1%	31.0%	12.1%	21.8%
Prognosis	14.6%	19.1%	47.3% (Recovered)	19.0%
Ability to Return to Work	21.6%	17.7%	41.6% (Already RTW)	18.9%
Permanent Restrictions	13.9%	15.6%	49.1%	21.0%
Referral Recommendations	8.7%	--	1.5% (Inappropriate)	89.8%

Auditors' Analysis of Physical Examinations, Diagnoses, and Rested Areas of Opinion

MedFx auditors felt that the physical examinations were appropriate in scope most of the time (Table 10). Diagnostic accuracy was not always consistent with evidence-based guidelines or even textbooks, however. Explanations of the examiner's analysis of other areas noted in Table 10 displayed a wide variation in completeness. The statistics on the need for reopening could be confusing; this was not an issue in most cases. The weakest area of explication was functional ability.

Table 10

Analysis

Analytic Item	Consistent w/ evidence	Somewhat Consistent	Unclear	Somewhat Inconsistent	Not Consistent	Not Recorded
Appropriate Parts of Body Examined?	87.3% (Yes)				12.7 (No)	
Diagnostic Accuracy	52.4%	32.1%	7.4%	3.7%	2.0%	2.3%
Causality	27.5%	26.7%	11.4%	7.7%	13.6%	12.3%
Need for Reopening	7.2%	3.2%	2.5%	--	--	84.0%
MMI Status	54.7%	22.7%	7.7%	2.3%	1.4%	11.1%
Ability to Return to Work	26.4%	23.0%	5.1%	1.9%	1.3%	42.4%
Functional Ability	16.0%	27.9%	8.3%	1.5%	1.4%	43.8%
Impairment Rating	35.8%	22.1%	12.8%	7.4%	3.2%	14.3%
Treatment Recommendations	62.9%	21.7%	7.4%	3.7%	2.3%	2.1%

Overall Work Product Quality

Most areas of work product quality were perceived to fall above the balance point between positive and negative scores. The majority of reports did not score as high as one would like (Table 11). The strongest area was responsiveness to the questions asked, and the weakest was the explanation of logic used, for the non-medical audience as well as auditors and quality improvement efforts. Auditors felt that boilerplate language was present more often than desired.

Table 11

Overall Work Product

Area	Excellent	Good	Moderate	Fair	Poor
Organization of Report	33.6%	36.6%	25.6%	3.8%	0.3%
Writing Clarity	36.1%	33.9%	32.8%	6.3%	0.9%
Boilerplate	60.1% (a boilerplate pattern did not exist)				39.8% (yes, a boilerplate pattern existed)
Language Level	43.5%	30.2%	23.1%	2.9%	0.3%
Appropriateness to Complexity of Case	43.8%	49.5%	--	4.2%	2.5%
Responsiveness to Questions	45.2%	48.0%	2.6%	0.2%	3.9%
Medical Logic Consistent with Evidence	33.2%	44.9%	7.8%	10.0%	3.5%
Opinion Consistent with Medical Logic	31.3%	44.1%	8.5%	10.6%	4.3%
Logic Stated	6.0%	20.1%	26.1%	16.6%	30.5%
Probability Consistent with Medical Logic	14.5%	22.1%	32.2%	20.4%	10.4%

Impartiality

The auditors felt the majority of reports were impartial. Hints of bias were derived primarily from acceptance of illogical or unsupported statements made by treating physicians or prior examiners, or from primary conclusions not supported by the data presented or by the evidence base. There were few overt statements that conveyed bias.

Table 12

Impartiality

Bias	Proportion
Neutral	67.6%
Possible Worker Bias	10.5%
Definite Worker Bias	1.0%
Possible Insurer Bias	4.0%
Definite Insurer Bias	0.3%
Indeterminate	15.9%